

**YOUTH SERVICES  
FAMILY AND MEDICAL LEAVE ACT  
EMPLOYEE REQUEST FORM**

Date of Request: \_\_\_\_\_

Employee Name: \_\_\_\_\_

Personnel Number: \_\_\_\_\_

Home Address: \_\_\_\_\_

Street

City

State

Zip Code

Home / Cell Telephone Number: \_\_\_\_\_

Agency: \_\_\_\_\_

Unit: \_\_\_\_\_

FMLA request is for: ☐ Self

☐ To care for a family member

Name of family member: \_\_\_\_\_

Relationship: \_\_\_\_\_

If married, is your spouse a state employee? ☐ Yes ☐ No

Briefly explain reason for FMLA request: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Start date of anticipated leave: \_\_\_\_\_

Expected date of return: \_\_\_\_\_ Employee Signature: \_\_\_\_\_

Date: \_\_\_\_\_